

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2565-63-008260  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

**FILED MAR 14 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>St Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <i>Bel-Ridge 4016</i>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL #1</b>		d. STREET ADDRESS (If outside, give location) <i>2744 Hanley Rd</i>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>John</b> Middle Last <b>Anderson</b>		4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1963</b>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>1/17/77</i>
9. AGE (last birthday) <i>86</i>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Best Factory Sweden</i>	
11. BIRTHPLACE (City and state or country) <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY <i>Sweden</i>	
13a. FATHER'S NAME <i>Unknown</i>		13b. MOTHER'S MAIDEN NAME <i>Unknown</i>	
14. NAME OF HUSBAND OR WIFE <i>None</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>David Engelland 2744 Hanley Rd.</i>	

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHOLANGITIS</b> DUE TO (b) <b>CHOLEDOCHOLITHIASIS</b> DUE TO (c) <b>CHOLELITHIASIS</b> 584x		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <i>2-10-63</i> to <i>3-4-63</i> and last saw him alive on <i>3-4-63</i> Death occurred at <i>2:55 p.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Donald K. Bach, M.D.</i>	22b. ADDRESS <i>1515 Lafayette Avenue</i>	22c. DATE SIGNED <i>3-4-63</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>3/6/63</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>	23d. LOCATION (City, town, or county) <i>Normandy</i>	(State) <i>Mo</i>
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24. FUNERAL DIRECTOR <i>Calvin Kelly</i>	ADDRESS <i>7267 Natural Bridge</i>	25. DATE RECD. BY LOCAL REG. <b>MAR 6 1963</b>	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK  
OR  
TYPEWRITER RIBBON

VS 300  
Rev. 4/59

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*James A. Lemmings*

Licensed Embalmer No. 4142

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.